ASH
SMOKING AND HEALTH REVIEW

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First World Conference on Nonsmokers' Rights Rescheduled and Expanded—at No Additional Cost

The First World Conference on Nonsmokers' Rights, originally scheduled to be held from 9:00 a.m. to 5:00 p.m. in Washington, D.C., on Saturday, May 18, 1985, has been expanded and rescheduled to permit greater participation and a wider range of activities. The rescheduled conference will be held on OCTOBER 5, 1985, and will now include—in addition to seven workshops on virtually all aspects of the nonsmokers'-rights movement—two plenary sessions for the open and unstructured discussion of mutual concerns and ideas, and a press conference with media representatives in the nation's capital. **Places at the conference are strictly limited and will be reserved as of the date that fully paid applications are received at ASH.**

As described in recent issues of the *ASH Review*, representatives of major nonsmokers'-rights groups, meeting at the Fifth World Conference on Smoking and Health in Canada during the summer of 1983, suggested that there should be a conference in approximately two years focused primarily on the issue of nonsmokers' rights. When earlier discussions between leaders failed to produce any concrete plans, ASH made a survey that disclosed widespread support for such a meeting. The results of the survey also indicated a desire not only to focus exclusively on nonsmokers' rights (as distinguished from antismoking in general), but also to have sessions primarily in the form of workshops teaching concrete skills, rather than simply presenting papers.

ASH therefore tentatively scheduled the conference for May 18, 1985. However, a number of unexpected developments occurred. First, slow third-class mail delivery meant that many of our readers had less than one month's notice of the conference and were unable to respond in time. Second, many who had already made prior commitments asked that the conference be postponed to permit them to attend. Third, many of the people signing up had experience and expertise to share, which could not be easily incorporated into a one-day workshop-type conference. Finally, many actual or potential attendees also expressed the desire for at least one unstructured session in which activists could meet informally to trade ideas and plan strategies.

In response to these developments, the First World Conference on Nonsmokers' Rights has been rescheduled for October 5, 1985. This will provide more than adequate notice to all interested individuals and organizations, and help avoid scheduling conflicts. It will also permit announcement of the conference to reach a wider range of potential attendees.

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In Memoriam Dr. Luther L. Terry

This issue of the *Smoking and Health Review* is dedicated to DR. LUTHER L. TERRY, the grandfather of the antismoking movement, and a champion of nonsmokers' rights—with thanks from a grateful and healthier nation, and from Action on Smoking and Health (ASH). See p. 3.

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Nonsmokers' Conference

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In addition, the conference itself has been substantially expanded. For those who can arrive the night before, a two-hour Open Plenary Session has been scheduled for Friday evening, October 4, to permit informal discussion of mutual concerns and ideas. Also added to the conference are a question-and-answer session, a two-and-one-half-hour closing plenary session, and an informal (dutch treat) dinner get-together—all on Saturday. Leaders of major nonsmokers'-rights groups, and other leaders in the field, will also be invited to meet with the Washington, D.C., press corps at a Saturday morning press conference, and ASH will assist in setting up interviews throughout the weekend.

Although the conference has been substantially expanded, with the total hours almost doubled, ASH has kept the original cost—$75. Moreover, our objective of providing training in virtually all aspects of nonsmokers'-rights activity during one day on a shoestring will still be achieved. **Please remember that, as all conference sessions will be held in one room, attendance must be limited. Therefore, it is important that you send in your application—with a check for $75—as early as possible.**

It is hoped that all antismoking organizations will be able to send at least one representative to this first-of-its-kind gathering. ASH also asks antismoking groups and individuals to examine the tentative program, and to send to ASH any materials (booklets, reports, etc.) that might be helpful and any ideas that should be included. ASH plans to duplicate some material for distribution to the attendees, and hopes that groups will help by submitting samples of materials that ASH can consider for possible duplication.

Conference Agenda and Registration Form, pp. 14-15

"Pill" Dangerous Mostly for Smokers

Contrary to popular belief, birth control pills are relatively safe except for smokers and older women. According to the American College of Obstetricians and Gynecologists (ACOG), most of the 500 pill-related deaths each year are among women over 40 or women who smoke. Presented below are the number of deaths per 100,000 women caused either by the use of a birth control technique or by pregnancy that occurred when it failed. For reference, a woman's risk of death from childbirth or automobile accidents is about 10 per 100,000.

	Mortality Rate per 100,000 (by Age)		
Method	15-24	25-34	35-44
IUD	1.2	1.3	2.0
Combination "Pill"—NONSMOKERS	0.6	1.6	23.0
Combination "Pill"—SMOKERS	3.0	10.2	84.5
No birth control method	7.2	12.0	27.0

You can help by making this information available to others. Young women who wish to use the "pill" should be reminded that the risk is substantially greater if they smoke, and that the risk will increase as they get older. This information may help to counter the unfortunate tendency of young women to take up smoking to show their independence, as they are all too effectively encouraged to do in some cigarette ads.

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Infant Mortality Studies Target Smoking

Calling the slowing in the decline of the nation's infant mortality rate "disquieting" and "worrisome," the Public Health Service has suggested, among other things, more public education about the risks of smoking during pregnancy. "For example," the study recommended, "doctors and other health professionals can warn women of childbearing age before they become pregnant about the dangers associated with smoking and alcohol and drug use."

At about the same time the Institute of Medicine, a part of the National Academy of Sciences, said in a report, "Policy makers and health professionals know enough at present to intervene more rigorously to reduce the incidence of low birth weight in infants. Methods already available have demonstrated their value in reducing low birth weight." Smoking by pregnant women is, of course, a major factor in infant mortality and low birth weights.

Meanwhile, Governor Kean of New Jersey, chairman of the National Governors Association Committee on Human Resources, said that infant deaths were "most often the result not of genetic faults, not of inadequate medical knowledge, not of disease, but of social factors," including "substance abuse."

And Southern governors, alarmed at the generally higher infant mortality rates in their states, formed a Task Force on Infant Mortality headed by the governor of South Carolina—the state that not only has the nation's highest infant mortality rate, but also is a major grower of a substance that is a major factor in infant deaths across the country.

In the most recent estimate, cigarettes are held responsible for causing the deaths of approximately 4,000 infants each year, a figure that does not include infants killed in cigarette-caused fires. This figure represents almost 10 percent of *all* infant deaths in the U.S. in 1980 (45,526), and more than 10 percent of all infant deaths in 1984 (39,200).

Maternal Smoking Creates Legal and Ethical Problems

Now that it is known that smoking by expectant mothers creates a wide variety of serious health risks for the smallest and most vulnerable "involuntary smokers" (see "Abusing Children by Smoking," in this issue), there is growing debate about what should be done beyond educating mothers-to-be about the hazards of smoking and helping them to quit.

A body of legal and medical opinion, loosely known as the "fetal-rights movement," argues that the government has as much right and duty to protect a fetus against maternal negligence as it has to protect a child against abuse by his or her parents. For example, Dr. Margery W. Shaw, a physician, lawyer, and professor of

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Dr. Luther L. Terry, 73, Is Dead; Warned Public of Cigarette Peril

By ERIC PACE

Dr. Luther L. Terry, who as Surgeon General of the United States was instrumental in preparing a 1964 report that said cigarette smoking contributed so substantially to the death rate that "appropriate remedial action" was called for, died Friday in Philadelphia, where he had lived for 20 years. He was 73 years old.

Family members said Dr. Terry died at Pennsylvania Hospital after suffering a heart attack.

The report, which did much to discourage Americans from smoking and helped lead to a variety of measures to curb the adverse effects of smoking, was prepared, at President Kennedy's initiative, to help the Government determine what to do about the issue.

The report was prepared by a committee of 10 prominent scientists led by Dr. Terry, a former cigarette smoker who had switched to a pipe by the time the report came out. Dr. James M. Hundley, the Assistant Surgeon General, was vice chairman, and Dr. Eugene H. Guthrie, chief of the Division of Chronic Diseases in the Public Health Service, was the staff director.

A Problem of 'National Concern'

The panel began its work in mid-1963, assessing and organizing thousands of documents on earlier studies concerning the relationship of smoking and health; it did not do original research. The 387-page study, which was 14 months in preparation, contained roughly 150,000 words.

Dr. Terry, a soft-spoken, Alabama-born physician, said at a news conference in Washington on Jan. 11, 1964, when the report was made public, that the problem of cigarette smoking was one of "national concern."

The report concluded that there was no question as to the role of cigarette smoking in causing lung cancer. It said the death rate from lung cancer, the most frequent form of cancer in men, was almost 1,000 percent higher in men who smokeed cigarettes than it was in nonsmokers.

The report said cigarette smoking was the "most important" cause of chronic bronchitis and increased the risk of death from that disease and from emphysema. The report also said that in cases of coronary artery disease, the leading cause of death in the United States, mortality was 70 percent higher for cigarette smokers than for nonsmokers.

A Blow to the Tobacco Industry

The committee made no specific recommendations for action, but its report was seen at the time as dealing a heavy blow to efforts mounted in previous years by the tobacco industry in defense of cigarette smoking.

The report dismissed arguments questioning the validity of earlier studies, but the Tobacco Institute, an industry group, rejected the study, contending that it was not the final word on smoking and health.

For the rest of his career, Dr. Terry remained largely concerned with the dangers of cigarette smoking. After serving as Surgeon General from 1961 to 1965, he declared in 1967, when he was chairman of the National Interagency Council on Smoking and Health: "The period of uncertainty is over. There is no longer any doubt that cigarette smoking is a direct threat to the user's health. There was a time when we wpoke of the smoking and health 'controversy.' To my mind, the days of argument are over."

"Today we are on the threshhold of a new era," he went on, "a time of action, a time for public and priate agencies, community groups and individual citizens to work together to bring his hydra-haded monster under control."

19 Million Quit Smoking

By then, Dr. Daniel Horn, director of the National Clearinghouse on Smoking and Health, said 19 million Americans had quit smoking, but almost 50 million other Americans continued to smoke and more than a million young people began smoking each year.

Luther Leonidas Terry was born in Red Level, a small town in southern Alabama, on Sept. 15, 1911, the son of James Edward Terry and Lula M. Durham Terry. He earned a bachelor of science degree from Birmingham-Southern College in 1931 and an M.D. from Tulane University in 1935.

After a succession of medical teaching and research posts, he was called to active duty in the Public Health Service in 1942, and became chief of medical service in 1943 at what was then the United States Marine Hospital in Baltimore, a post he held for almost a decade while also teaching and doing some research at Johns Hopkins University.

1974

Dr. Luther L. Terry

In 1944, Dr. Terry became a member of the Regular Commissioned Corps of the Public Health Service. In 1953, he became a full-time medical researcher with he National Heart Institute, becoming assistant director in 1958 and concentrating on the problem of hypertension.

Concern for the Workplace

He was named Surgeon General in 1961 and remained in that post until 1965, when he became vice president for medical affairs and a professor at the University of Pennsylvania. He retired as a professor in 1982.

In his last years, one of Dr. Terry's chief medical interests was cigarette smoking in the workplace. In public appearances around the country, he argued that companies should take steps to prevent nonsmoking employees from being exposed to cigarette smoke.

Over the years, he was awarded 17 honorary degrees.

Dr. Terry is survived by his wife, Janet Reynolds Terry, whom he married in 1940; two sons, Luther L. Terry Jr. of Singapore and Michael Durham Terry of Old Greenwich, Conn.; a daughter, Jan Terry Kollock of Philadelphia; a brother, Durham Terry of Red Level, a sister, Elizabeth Terry White of Charlotte, N.C., and three grandchildren.

Michael Terry said Friday that his father would be buried at Arlington National Cemetery, but funeral and burial arrangements were not yet complete.

TERRY—Luther L., on March 29, 1985, of Philadelphia, husband of Janet (nee Reynolds). Service Tuesday, April 2 at 1PM in the Chapel of Arlington National Cemetery, Fort Myer, Va. Interment in Cemetery. Memorial service in Philadelphia will be announced at a later date. In lieu of flowers, contributions may be sent to Action on Smoking and Health, 2013 H. St, NW, Washington, D.C. 20006 or the American Lung Association, 1740 Broadway, NY, NY 10019.

THE NEW YORK TIMES, SUNDAY, MARCH 31, 1985

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ASH Helps Fight Tobacco Subsidies

ASH joined with representatives from diverse groups, Congressman Thomas Petri (R-Wisconsin), Senator Howard M. Metzenbaum (D-Ohio), and others in a nationally reported press conference promoting the "Tobacco Deregulation Act of 1985." Organizations with spokespersons at the conference included the American Lung Association, Action on Smoking and Health, Consumers for World Trade, Council for a Competitive Economy, National Taxpayers Union, and the United Tobacco Growers.

Several tobacco farmers spoke at the conference, arguing for the end of governmental interference in the tobacco industry, which is driving tobacco prices so high that American-grown tobacco is no longer competitive in the world marketplace. A growing number of former tobacco farmers are reportedly switching to other crops or getting out of farming entirely; others are cutting back the amount of tobacco they grow. Last year was a disaster for many, and early indications are that this year will not be much better. Many blame the antismoking and nonsmokers'-rights movements also.

A major objection to the current programs from organizations not primarily concerned with the health hazards or moral implications was the enormous costs. These include—

- Annual administrative costs — $15 million
- USDA-admitted losses of principal on crops through 1981 — $81 million
- GAO estimated interest costs to 1981 — $591 million
- USDA-projected losses on '76-'81 crops still in storage, not including understated interest costs — $450 million
- Understatement of interest costs on 1982 flue-cured crop due to lack of compounding, as estimated by USDA Inspector General — $164 million
- Annual subsidy to allotment owners in form of allotment rent — $800 million

These enormous costs compare with a paltry $3.5 million allocated to the other side, the Office on Smoking and Health, for fiscal 1985. U.S. taxpayers are also spending over $3 million a year on a search for a "safe" cigarette —a goal that most scientists believe is a fantasy.

ASH Executive Director John Banzhaf raised a number of additional concerns in his statement at the press conference:

"Nonsmokers, worried about the rising costs and even greater future financial risks of the tobacco subsidy program, and about the moral and ethical implications of being forced to support a product that kills over 350,000 Americans each year, are calling upon the federal government to get out of the tobacco business by eliminating the tobacco support program.

"Many Americans object on moral and ethical grounds to being forced to help support a product that annually kills 350,000 Americans, and disables and addicts millions more. Unlike other farm products that help to feed or clothe people, and cause health problems only if used in excess, tobacco is dangerous for all who use it regularly, and provides little social benefit other than to satisfy the cravings it itself causes. Several major religious organizations —including the Southern Baptist Convention and the North Carolina Council of Churches—recently spoke out on the moral and ethical issues of raising a killer crop.

"At a time when reducing the federal deficit is essential, the product that kills more Americans than all others combined; that for over 30 years has escaped paying its fair share of federal taxes; that costs the American public well over $100 billion each year, most of which is borne by nonsmokers; and is the major source of indoor air pollution, residential fire deaths, and many other related problems, should not escape the axe.

"Quitting smoking is easier if done once and for all, rather than by tapering off bit by bit. Likewise, the government should give up tobacco support cold turkey—now—rather than trying to gradually taper off a program most reasonable observers know is doomed in the long run."

ASH Wins on Airplane Smoke Detectors

The Federal Aviation Administration (FAA) announced on March 26, 1985, that it will require smoke detectors in the lavatories of all large airliners. ASH had petitioned the FAA to require lavatory smoke detectors as well as automatic fire extinguishers, which will also become mandatory.

Under the order, airlines will have 18 months from April 29, 1985, to install the smoke detectors, and 24 months from the same date to install the automatic fire extinguishers. Muse and Pan American have already installed the smoke detectors, and several models of airplanes already have the automatic extinguishers.

The FAA's decision and ASH's request were both spurred by a fire on June 2, 1983, aboard an Air Canada DC-9 flight from Dallas to Toronto. A fire in the lavatory forced an emergency landing and killed 23 passengers. The exact source of the fire has never been determined by the government, even though ASH produced evidence indicating that a smoker, irate at having been prohibited to smoke in the no-smoking section, stormed into the lavatory with the cigarette and shortly thereafter left without it.

In any event, ASH was able to show that cigarettes are frequently smoked in the lavatory and/or thrown into the lavatory trash container. A smoke detector may not only provide early warning of a serious fire, it may also prove an effective deterrent to smoking in the lavatory, a practice that has been prohibited for some time but is difficult to prevent without a smoke detector.

Unfortunately the new rules do little for the problem posed by smoking in the passenger cabin of the aircraft, where cigarettes frequently fall on the floor, on the seats, or on passengers' clothing. However, the rule does require airlines to increase the number of fire extinguishers on board.

Tobacco Suits Scare Industry and Analysts; ASH Helping Find More Plaintiffs

Existing and potential suits against the tobacco industry, spurred and supported by the ASH-assisted Tobacco Products Liability Project, are already scaring cigarette manufacturers and causing analysts to paint a grimmer picture of the industry's prospects. ASH, meanwhile, is playing a unique role by helping to find plaintiffs for lawyers eager to join such litigation.

Tobacco industry analyst William Miller, of Legg Mason Wood Walker, Inc., in Baltimore, didn't hesitate to tell *USA Today* that litigation charging that smoking is addictive is "one possible cloud on the horizon" for the industry. "It's up to a jury to make the judgment as to [whether it is addictive]" said Miller. "My concern is that there could be very large jury awards. These companies are generally loaded with cash, and they're certainly targets of opportunity to certain people," he said.

Distributor magazine predicted that "product liability lawsuits could pressure tobacco companies the way asbestos producers have experienced." The *New York Times,* in a major article entitled "Antismoking Climate Inspires Suits by the Dying," says that "lawyers involved in the latest cases, along with some scholars, say that much has changed in the last 15 years and that such suits may now prevail."

The *Times* also quotes ASH Executive Director John Banzhaf as saying, "Suits against tobacco companies will soon make other toxic tort cases, like Agent Orange, asbestos, or DES, look like preliminary bouts before the heavyweight match." The publication *Lawyers Alert* quotes Prof. Banzhaf as saying that "cigarette suits could make every other toxic tort area look like kindergarten," and recommending that lawyers interested in suing tobacco companies contact ASH for assistance. And the *Wall Street Journal* featured the issue on its front page.

EDITOR'S MEMO From *Tobacco Reporter*, March 1985

By Anne Shelton

IF SOME ATTORNEYS IN THE UNITED STATES have their way, 1985 could become the year of precedent-setting courtroom battles in product liability suits against the tobacco industry. One case comes to court this month in California and nearly a dozen others are expected to hit the dockets in the next few months. The largest is a $9.3-billion suit filed in Charleston, West Virginia, against all six major U.S. cigarette manufacturers and eight of their advertising agencies. Leading the upcoming California case is attorney Melvin Belli, who has stated publicly that if he wins, he will donate one-third of the settlement to cancer research. He also says he wants smokers to be seated on the jury because they are so well aware of the nature of their addiction.

Not depending just on public sympathy—or blind luck—to win, torts attorneys across the country have begun to combine their resources, both among themselves and with established anti-smoking forces. One lawyer in Massachusetts turned to Action on Smoking and Health (ASH) for assistance in organizing some of his colleagues who are engaged in liability suits against tobacco. The result of their combined efforts is called the Tobacco Products Liability Project. Its stated purpose: to share information. One must infer that also includes strategies, expertise, and so forth.

The Project intends to work closely with anti-tobacco groups such as ASH, and the reason for this cooperation goes well beyond information sharing. It is illegal in the U.S. for attorneys to solicit cases, unless the case is considered pro bono publico. The restriction applies also to groups of attorneys, such as the Tobacco Products Liability Project. But ASH and other such groups are not lawyers and are, therefore, permitted to solicit, according to a Supreme Court ruling.

Product liability suits are not new, and while none against tobacco companies has ever been successful, many tort attorneys now say they think it's just a matter of time before some plaintiff wins, setting a precedent that will encourage more suits to be filed. A grim scenario indeed for the industry worldwide.

ASH can play a key role by alerting those who have been injured that they have the right to sue, and by attempting to assist victims in finding lawyers willing and able to represent them. As the *Tobacco Reporter* warned its readers, this is an activity that ASH is in a unique position to undertake. So ASH is actively looking for people who fall into one of the following categories and are interested in bringing suits against tobacco companies:

1. People suffering from a serious disease, such as lung cancer or emphysema, that has been positively diagnosed as having been caused by smoking. It would be helpful, but is not essential, that the victim have smoked only cigarettes made by one particular manufacturer, and that he or she live in a state that is generally favorable to plaintiffs in product liability suits.

2. People seriously injured in a fire that was definitely established as caused by a cigarette. The strongest suits can be brought by those who had no connection whatsoever with the careless smoker, such as guests in another room of a hotel, or patients

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Anti-Tobacco Suits Scare Industry

Continued from page 5

in a hospital or nursing home.

3. People who have suffered from a serious disease, such as cancer of the mouth, that was positively diagnosed as having been caused by using smokeless tobacco.

4. People who suffered an immediate and severe reaction involving the lungs shortly after puffing on a cigarette containing cloves. ASH Executive Director John Banzhaf appeared on the "Today" show on March 15, 1985, to help warn the public about this new product, which has already taken the lives of several individuals and seriously injured thousands of others.

Where a victim in one of the above situations has already died, relatives may wish to consult with the attorney handling the estate to see if a torts action is still possible. Also, physicians, nurses, and others who come in contact with such people may wish to refer them, or their attorneys, to ASH for further advice. **Please help ASH to help these people, and to make cigarette manufacturers pay for the death and disability they cause.**

Ideas for Activists

Especially for health-care providers. Family practice physicians at Castle Air Force Base in California have a two-pronged approach to discourage the use of tobacco. Each month they conduct stop-smoking classes for those hooked on the weed, and they also go around to junior high schools to let seventh and eighth graders know about the hazards of smoking.

Plagued by employee smoking at her bank, a Wisconsin activist removed her money and invested it in another bank. She also notified a bank official that if no smoking policy were instituted, she would remove the funds she had in longer-term certificates of deposit as soon as they came due.

From the newsletter of Georgians Against Smoking Pollution: **"In a restaurant, put the ashtray on the floor.** If you just put it on another table, the employees and other customers think it was put there to use. On the floor, it will tell them something!"

After trying for years to get the *New York Times* to discuss publicly its cigarette advertising policy, Dr. George Gitlitz of Doctors Ought to Care (DOC) decided to fight fire with fire: He and DOC bought ad space **to challenge the newspaper to tell its readers why it continues to carry cigarette ads.**

Tobacco Deaths Top 500,000; Deaths Certificates Should Name Tobacco

At least half a million Americans die each year from the effects of tobacco—more than one fourth of ALL American deaths from ALL causes—and deaths certificates should reflect this fact. These are two of the startling conclusions and recommendations contained in a new study published in *Population and Development Review* by Dr. R. T. Ravenholt, director of World Health Surveys, Inc.

Using the most recent available mortality statistics (1980) and data from large epidemiological studies of smokers, Dr. Ravenholt calculates that cigarettes killed 485,000 people in 1980. Today, he says, the total number is over half a million, especially if one includes deaths from passive smoking and the use of pipes, cigars, and smokeless tobacco.

Dr. Ravenholt estimates that "mortality during 1980 attributable to abuse of all addictive substances probably totaled about 630,000 deaths—500,000 from tobacco, 100,000 from alcohol, and 30,000 from other addictive substances—which is nearly one-third of all deaths from all causes [1,989,841]." This led him to conclude that "tobacco is an environmental hazard equal to all other hazards to life combined, one deserving of our utmost preventive measures. Only the unquantifiable threat of nuclear annihilation poses a greater threat to human health and life."

The study explains that the number of deaths attributable to tobacco has been dramatically underestimated in the past because on the death certificate the cause of death is given as the disease existing at the time of death, rather than the cause of the disease. Under this procedure, heart disease, cancer, and strokes have traditionally been listed as the top three killers in the U.S.

But this practice obscures the fact that many of these deadly diseases were caused by substance abuse, and that tobacco is far and away the leading killer substance. These antiquated procedures also ignore the fact that although at the turn of the century most deaths were caused by the "enemy from without" (e.g., germs), today a much larger proportion are caused by lifestyle choices ("the enemy within"). "The old way of writing death certificates is a mindless hangover from a more primitive medical era," Dr. Ravenholt said. "Physicians need to break the old habit and put down what really killed a patient." Ravenholt recently stated in the *Journal of the American Medical Association,* "A key reason for this tragic neglect of 'the enemy within' has been the ongoing failure of 'physician sentinels' to certify smoking as the underlying cause of death for persons actually dying of smoking."

U.S. Deaths in 1980 Attributable to Cigarettes

Cancer	147,000
Heart, vascular diseases	240,000
Respiratory diseases	61,000
Digestive system	14,000
Infant mortality	4,000
Fires, other accidents	4,000
Other miscellaneous	15,000
Total deaths attributable to cigarettes	485,000
Total of all deaths in USA	*1,989,841*

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ASH SPECIAL REPORT

Consumer Reports Article on Second-Hand Smoke

The February 1985 issue of *Consumer Reports*, published by Consumers Union (CU), contained an article entitled "The Murky Hazards of Second-Hand Smoke." The conclusions, as stated in CU's own summary, were that "the evidence so far suggests harm to children, not to healthy adults." ASH immediately responded with a letter critical of the article—which was published in our last issue—with a copy also sent to CU for publication. CU refused to publish this letter, even though a CU staff member had called ASH to ask that we send such a letter and strongly hinted that it would be published. CU has also received a number of other critical and detailed letters from leaders in the field, which it likewise declined to publish.

Subsequently, ASH, after consulting with others, prepared a detailed analysis of the article. The analysis indicated that the article was flawed in many ways, and that the flaws were so serious and pervasive that, coupled with the article's blatant editorializing, they create a strong implication, not simply of carelessness, but of deliberate bias.

ASH sent this analysis to CU for comments and appropriate corrective action. But it was not until copies of the analysis had also been sent to members of the CU board, together with a formal complaint, that CU replied at all. The reply only made matters worse, since it contained additional misstatements and implausible explanations.

Since many people trust Consumers Union and *Consumer Reports* for their supposedly fair and unbiased reporting on many issues, and because the tobacco industry is using the CU report in legislative proceedings and elsewhere to bolster its contentions, ASH presents this detailed analysis of the *Consumer Reports* article.

Why the *Consumer Reports* Article, "The Murky Hazards of Second-Hand Smoke," Is Unfair, Deceptive and Apparently Biased

"The Murky Hazards of Second-Hand Smoke," published in the February 1985 issue of *Consumer Reports*, concluded that the "evidence so far suggests harm to children, not to healthy adults" (CU's own summary in the Index, P. 62.)

To reach that conclusion, the article was forced to rely upon outdated information and studies; quoted, as the tobacco industry does, from conferences (where anything can be said) rather than peer-reviewed articles in reputable journals; mischaracterized and overstated objections to critical studies; deliberately misrepresented (by omission and otherwise) the conclusions of the U.S. Surgeon General; failed even to mention—much less to apply—the scientific standards which should be used in assessing the evidence; and used techniques of analysis totally inconsistent with those used in evaluating other similar dangers, including the analysis of the dangers of kerosene heaters in the very same issue. Perhaps most importantly, the choice of words used in the article—which clearly amount to editorializing rather than reporting—indicate a strong bias concerning the issue, which almost certainly helps to explain the erroneous conclusions reached.

The following is an analysis of some of the major problems with the article. The points are raised roughly in the order in which they appear in the article, with citations to the page and column.

1. The article begins [P. 81, C.1] with a heavy dose of sarcasm designed to belittle those concerned about the health problems of ambient tobacco smoke, and to suggest that the steps being taken to deal with it are medieval in their cruelty and lack of reasonable basis. Thus, instead of beginning by noting that ambient tobacco smoke is the most prevalent indoor air pollutant and possibly the most dangerous, so that questions concerning its risks are of primary importance, it notes that selling "no smoking signs is becoming a brisk business"; compares the current reaction to executing, imprisoning and confiscating the property of smokers, and states that the smoker "is fast becoming a social pariah, *banished* to the rear sections of aircraft and *barred* from an increasing variety of public places." (These and subsequent emphases are ASH's.)

Aside from the totally unscientific and nonobjective attempt to poke fun at and make light of a major public health problem, the latter statement quoted above is both incorrect and misleading. Smokers may, of course, go in any portion of an aircraft they wish, and in any public place. All they are required to do while there is to refrain from smoking, as others may likewise be required to refrain from chewing and spitting (which provides roughly the same nicotine satisfaction), burning incense (which likewise provides satisfaction to the user while polluting the air with smoke), or from playing loud music, using loud and abusive language, or engaging in a variety of sexual activities. This is far different from a "banishment" or from the clearly reprehensible (former) requirement that blacks sit at the back of buses; since the latter was based upon immutable characteristics, whereas the former merely restricts an activity which, at the very least, is annoying and irritating to others, for a normal period of time.

2. The article then states [P. 81, C. 1] that the Boeing Company prohibits

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smoking on the job, and that four states restrict smoking in the workplace. Both of these statements are factually incorrect and provide some indication of the lack of care and accuracy which went into the preparation of the article. In fact, there are five states which restrict smoking in virtually all workplaces, and an additional five states which restrict smoking in governmental workplaces. Not stated at all in the article is the fact that 38 states and literally hundreds of cities, counties and towns have passed laws restricting smoking in many public places; a rather clear indication not only of the importance of this topic, but of the conclusion of thousands of legislators that there is or may be a serious health hazard. The Boeing Company does not prohibit smoking in its workplaces.

3. The article then goes on to state [P. 81, C. 1 and 2] that the "*presumed health consequences* of 'passive smoking' rest on a very *few* undisputed facts"; that the "evidence of *risk* from passive exposure is *sparse* and often *conflicting*" and that "the only area of current agreement involves potential consequences in children, especially the very young, and in the developing fetus." All of this is factually incorrect, and no longer seriously in dispute. While there is some question about increased *mortality* from passive smoking, many other health hazards of passive smoking are totally undisputable.

For example, there is no question whatsoever that millions of adults and children—one conservative estimate numbers 34 million—are particularly susceptible to ambient tobacco smoke because of a wide variety of conditions, such as chronic sinusitis, asthma, hay fever, chronic bronchitis, emphysema, and other problems. Exposed to concentrations of ambient tobacco smoke common in many public places, they often require medication, a physician's intervention, and even hospitalization. Such situations have been repeatedly documented in court cases, in testimony before administrative agencies, and in the medical literature. Indeed, all CU or any other doubter has to do to confirm this fact is to open the Yellow Pages and telephone at random virtually any allergist or respiratory clinic, and the physicians there will describe patients who do and have suffered serious health problems from ambient tobacco smoke. Clearly a substance which causes many people to be hospitalized from exposure to it creates a "health consequence," or "health risk," by any reasonable definition of the term.

In addition, for the ordinary nonsmoker who has no particular susceptibility, the evidence is also undisputed (by anybody but the tobacco industry) that exposure in common situations likewise causes serious physical irritation and clearly observable medical symptoms (technically "signs"). Studies indicate that as many as 75% of nonsensitive nonsmokers will suffer serious physical irritations to eyes, the nose, nasal passages, or the throat. While these irritations are not life-threatening, they are nevertheless serious. Indeed, people who suffer from these very same symptoms—red, sore, or teary eyes; sneezing or nasal discharge; coughing, hoarseness, or sore throat, etc.—when not exposed to tobacco smoke, will ordinarily conclude that they have a cold or flu, would take appropriate medication, and frequently stay off from work and/or seek bed rest. These effects of ambient tobacco smoke are so well-known and so clearly demonstrated that CU or anyone else can confirm them simply by taking a poll of a dozen nonsmokers, and asking them whether they have suffered any of these symptoms when exposed to tobacco smoke. Prevalent national advertising for eye drops to relieve sore, red eyes caused by ambient tobacco smoke is another clear indication of how well-known and indisputable these adverse health effects are.

4. The article next [P. 81, C. 2] cites the 1979 Surgeon General's Report for the proposition that "Healthy nonsmokers exposed to cigarette smoke have little or no physiologic response to the smoke, and what response does occur may be due to psychological factors." This quote, while technically accurate, is totally misleading in the context of the CU article for two major reasons: Most of the major evidence of the health hazards caused by ambient tobacco smoke has been published subsequent to that report; and subsequent reports and statements by the Surgeon General completely contradict that original assessment which was made on the basis of the very limited evidence available in 1979. It is a clear indication of misleading reporting, and of the bias which permeates the article, that this out-of-date quote from the Surgeon General is included, whereas subsequent contradictory statements are not.

For example, the 1982 Surgeon General's Report on the Health Consequences of Smoking states that "involuntary smoking may pose a carcinogenic risk to the nonsmoker"; that it poses "a serious public health concern because of the large numbers of nonsmokers in the population who are potentially exposed"; and that "prudence dictates that nonsmokers avoid exposure to second-hand tobacco smoke to the extent possible." Dr. Edward M. Brandt, Jr., Assistant Secretary for Health, also noted that "nonsmokers should avoid being in smoke-filled rooms." [P. viii]

In 1984 the U.S. Surgeon General stated that there is "very solid" evidence that cigarette smoking can cause lung disease in nonsmokers and that there is a "provable relationship" between passive smoking and both illness and death in nonsmokers. For reasons which are totally unexplained, and which raise strong suspicions of bias, these subsequent statements by the nation's chief health official charged by Congress with assessing this risk are not even alluded to.

5. The CU article next considered the problem of measuring how much tobacco smoke a passive smoker is exposed to [P. 81, C. 3; P. 82, C. 1] and states that "measuring cotinine—the major biological byproduct of nicotine in the blood and urine—provides a reasonable index of exposure." Actually, cotinine provides, at best, a measure of exposure to only one toxic substance present in ambient tobacco smoke: nicotine, a chemical principally noted for constricting blood vessels, not for causing cancer. It is now well known that the smoke given off by an idling cigarette (one not being actively puffed) contains substantially greater concentrations of various carcinogens than a puffed cigarette, and that many other factors (e.g., relative weight, particle size, etc.) influence how much of each of the components of ambient tobacco smoke a nonsmoker may inhale. This is a crucial point because most of the rest of the analysis in the article is based upon this critical but dubious dosage assumption.

6. The CU article [P. 82, C. 1 and 2] then goes off on the issue of relative exposure to tobacco smoke in the home and on the job. While this inquiry might be relevant in evaluating the weight of some of the published studies—e.g., especially the Japanese studies—it is apparently not used for this purpose. Rather, the article seems to imply that these determinations are important because they provide the support for the aforementioned laws restricting smoking in the workplace. The article goes on to say that the current debate about passive smoking has focused on the workplace, which can be regulated, rather than the home, which effectively can't be: "But if the Japanese findings are correct, the heaviest exposures to tobacco smoke tend to occur in the home."

But this digression clearly has nothing to do with the scientific question of whether ambient tobacco smoke causes lung cancer but, rather, goes to the political and practical issues of attempting to regulate one form of exposure. While the practical problems of regulating smoking in the workplace are significant, the more important issue—the one supposedly addressed by the CU article—is whether ambient tobacco smoke can cause lung cancer in nonsmokers. This is of primary concern even if no workplace regulation were being considered. For example, if CU reported to its readers that ambient tobacco smoke did cause lung cancer, it is logical that nonsmokers would take extra precautions in the home to avoid exposure. It is reasonable to expect that smoking members of the household would likewise take added precautions to protect other nonsmoking members of their household. Seeking to intertwine these two issues only confuses the discussion on the principal scientific one, and downplays and tends to overstate the CU article's own admission that "there was again a significant difference in exposure between nonsmokers who worked with smokers and those who didn't."

7. The next major error in CU's article [P. 82, C. 3] was to place great reliance upon attempts during the 1970s by the National Cancer Institute to quantify the *mortality* risk for various diseases caused by smoking. Although the article does state that "[e]xtending the NCI's findings to passive smoking *may be premature*," and that there are *important scientific reasons for not doing so*—e.g., "passive smokers get low doses over a long period, while active smokers get their dose in high, intermittent bursts"—the author goes ahead and does so without citing any scientific authority or justification for his actions. A substantial portion of CU's article and the conclusions stated therein are based upon these NCI data. But there are several additional strong reasons why this technique of analysis should not have been used, especially by CU.

First, it must be noted that the NCI studies were made during the 1970s, prior to the great bulk of the evidence linking ambient tobacco smoke to health hazards in nonsmokers.

Second, the NCI effort related only to "*mortality risk*," not to the overall incidence of cancers.

Third, what the NCI attempted to determine as the "crucial value for each disease was the number of cigarettes average individuals could smoke daily without increasing their mortality risks measurably above that of *nonsmokers*." It is logically contradictory to attempt to determine the health risk ambient tobacco smoke causes to nonsmokers exposed to

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tobacco smoke by estimating the risks above those to which nonsmokers are already subjected. Indeed, the EPA study to which the CU article refers later notes that nonsmokers whose lifestyle tends to restrict their exposure to ambient tobacco smoke—e.g., Mormons—have a substantially lower rate of lung cancer than the nonsmokers in the NCI study.

Fourth, the conclusions cited by the CU article were primarily those of one researcher at NCI, Dr. Gio Gori, rather than those of the entire NCI or the Department of HEW (now HHS). For example, the consensus opinion on the risk of smoking one to two cigarettes a day was stated this way in the 1981 Surgeon General's Report: "There is no safe cigarette and *no safe level of consumption*."

Fifth, the CU article cites no authority—for example, an article published in a reputable medical or scientific journal—which would support the type of analysis it used. For a lay publication to attempt, on its own, to reach allegedly scientific conclusions based upon at least two different faulty assumptions—that cotinine is a reliable measure of the amount of passive smoking, and that measures developed to determine mortality based upon active smoking are accurate to predict lung cancer in passive smokers—was totally irresponsible, misleading, and may well be unprecedented. If these techniques of analysis were valid, isn't it likely that some reputable scientist would have used them in an article published in a journal somewhere?

8. In at least two places [P. 83, C. 1 and 2], the CU article cites conferences rather than published scientific articles as authority for major medical conclusions. This is a serious mistake and very misleading because many laymen, unlike CU, do not realize the limitations of such reports. Indeed, it is probably for that reason that the tobacco industry and R. J. Reynolds, in their national ad campaigns to deny the existence of evidence relating to the health hazards of ambient tobacco smoke, *do* rely so heavily upon conference reports, and virtually ignore the growing number of reports in major scientific and medical journals.

As CU should know, virtually anyone can say anything at a conference, and thus statements made at such conferences—or even papers presented at them—are ordinarily given little weight when compared to articles published in major medical and scientific journals which are subject to very careful peer review prior to publication, and extensive written criticism subsequent to publication. Also, the results of many conferences obviously depend upon the mixture of the small number of people who chose or were invited to attend.

As an example, the CU article cites an alleged discussion of a May 1983 conference sponsored by the Division of Lung Diseases of the National Heart, Lung, and Blood Institute. The CU article states "[t]hey concluded the evidence suggested that the effect of passive smoking 'varies from negligible to quite small.' However, the article does not point out several crucial factors. First, the conclusion related only to pulmonary function in children. Second, the conclusion reportedly was written only by the workshop chairman, and was not circulated to workshop participants for review. In fact, we are told that some of the participants disagreed with it. In addition, outside experts attempting to gain entry to the workshops were discouraged from attending, and experts from other parts of NHLBI and DHHS were not informed of the meeting. Finally, the conclusions of the workshop were not subject to peer review, and were not endorsed by the NHLBI. None of these very serious limiting factors was pointed out by CU.

If CU had investigated diligently, it would have learned that a favorite deceptive tactic of the tobacco industry is to sponsor conferences, or to attempt to "pack" conferences, with a small number of researchers who support its point of view. It then cites the conclusion of these conferences, as CU did, as an indication of the weakness of the evidence of the health hazards of ambient tobacco smoke. They ignore, as CU ignores, at least 14 different studies reported in responsible and prestigious medical journals such as the *British Medical Journal* and the *International Journal of Cancer*, which show a positive association between passive smoking and cancer.

9. The CU article next goes on [P. 83, C. 2 and 3] to disparage the study by Dr. Takeshi Hirayama in Japan showing that nonsmoking wives of smokers had twice the risk of developing lung cancer as nonsmoking women married to nonsmokers. To help refute the study, it cites a study by Dr. Lawrence Garfinkel of the American Cancer Society. However, the discussion of both is misleading and incomplete, and shows further evidence of bias for the following reasons.

First, CU's report totally ignores the fact that the Hirayama and Garfinkel studies, and the alleged problems with the former, were thoroughly analyzed by the U.S. Surgeon General in his 1982 Report. He and the Assistant Secretary for Health, both far more knowledgeable than CU, nevertheless gave far greater weight to the Hirayama study and concluded that the "evidence currently available suggests that involuntary smoke exposure may increase the risk of lung cancer in nonsmokers, but limitations in data and study design do not allow a judgment on causality at this time" [P. 250-51].

The Surgeon General also reported why the Garfinkel study probably reached the conclusion it did: That the author of the study himself noted various limitations in the analysis—e.g., the study was not designed to assess the effects of passive smoking; there was difficulty in measuring the involuntary exposure; and in less than 30% of the cases was it even possible to learn whether the husband smoked. Dr. Garfinkel is, of course, a statistician, not a doctor of medicine.

It is ironic that CU, like the tobacco industry and R. J. Reynolds, quotes from and relies upon the Garfinkel study. Dr. Garfinkel has publicly denounced this abuse and misuse of his report by the tobacco industry, a factor which might have indicated to CU that it should not make the same errors.

CU also failed to note the brilliant follow-up work which Dr. Hirayama did, and which was reported at the Fifth World Conference on Smoking and Health. In smokers tobacco smoke causes substantially increased cancer rates not only in the smokers' lungs but also the throat; the so-called "gateway" for smoke which the smoker inhales while puffing. Dr. Hirayama therefore reasoned that additional evidence supporting or refuting his initial conclusion could be gained by determining whether the "gateway" for ambient tobacco smoke likewise had an increased rate of cancer, since nonsmokers tend to inhale ambient tobacco smoke through the nose. He therefore reexamined his data for over 90,000 nonsmoking women in his study, and found indeed a substantially elevated level of cancer of the nasal sinuses. Further analysis of his data also indicated that both the lung cancer and nasal cancer in the wives of smokers were closely related to the amount of smoking the men did, and was not related to any of the other variables that Dr. Hirayama examined.

10. After spending most of the time ridiculing the issue, confusing it with policy considerations about banning smoking in the workplace, relying extensively on outdated and inapplicable NCI research, and citing conference reports rather than scientific studies, the CU article disposes, in approximately two paragraphs [P. 83, C. 3; P. 84, C. 1], of the irrefutable fact that there are now at least 14 reports in major medical journals showing that in humans there is a positive association between passive smoking and cancer. Although some of the studies involve relatively small numbers (presumably because of limitations in resources) and reach somewhat different quantitative conclusions, the common thread is that all provide very substantial evidence linking ambient tobacco smoke to lung cancer.

Also totally ignored is the fact that ambient tobacco smoke contains a number of well known carcinogens. Clearly, in large enough dosages, it can and does cause lung cancer in humans—a conclusion which is supported by perhaps more medical evidence than any other. CU also fails to report that no scientist, nor article, nor any report has ever established that there is a safe lower limit for exposure to any carcinogen, and that most experts in the field therefore believe that any exposure to a carcinogen creates some risk that a cancer will result. While many people may be willing to accept cancer risks when they are voluntarily assumed in connection with an activity which brings some pleasure (e.g., eating peanut butter), or when they are caused by some activity from which we all derive some benefit (e.g., radiation hazards from nuclear power plants), such is clearly not the case where nonsmokers are exposed to the carcinogens of ambient tobacco smoke.

11. CU's report does not mention until the end of the article [P. 84, C. 1 and 2], and then only in a cursory and disparaging manner, the most complete and comprehensive report on the subject, which is now before the EPA. Even here, its comments are at best incomplete and misleading, and provide even clearer evidence of bias.

For example, after mentioning the report by Repace and Lowrey and its conclusion that "passive smoking might be responsible for some 5,000 lung-cancer deaths annually in the U.S.," CU states that "[a]n internal review . . . criticized some of its main assumptions. The estimate of 5,000 lung-cancer deaths was judged questionable on various grounds." Yet, even a cursory reading of this internal review would have indicated to CU that it did not question in any way the basic underlying premise of the report and the issue now raised in CU's article. In short, it did not question in any way the conclusion that ambient tobacco smoke causes lung cancer in nonsmokers, and that hundreds of lung-cancer deaths among nonsmokers can be attributed to ambient tobacco smoke. The conclusion which was reached was that the lower limit of some 500 deaths a year

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from ambient tobacco smoke was "better supported" than the higher estimate of 5,000. Even so, the internal review stated that "even this [lower] risk would, given the size of the population exposed to passive smoking, translate into a significant population risk compared to other carcinogens found in ambient air." Indeed, also entirely omitted from the CU report was the conclusion shared both by Repace and Lowrey, and by the internal review, that the 500 lung-cancer deaths each year was far greater than all other cancer deaths attributed to all other air pollutants.

12. The CU report on this issue therefore concludes in short that the role of passive smoking in lung cancer, if any, remains unresolved. For the many reasons previously stated, it appears that this conclusion is totally unsubstantiated. Even more importantly, the CU article compounds its earlier inaccurate and misleading reporting by failing to acknowledge—much less discuss—a crucial issue: the standard of proof which should be applied to the evidence.

Scientists, legislators, public health officials, and others have long recognized the fallacy of waiting for absolutely conclusive, positive, beyond-a-reasonable-doubt type of evidence before taking action on public health problems. If action on such problems required this level of proof, millions of people would suffer and die needlessly, particularly from exposures to substances which cause problems such as cancers which often cannot be detected for dozens of years. If government required the level of proof CU seems to indicate is appropriate, it would not have taken regulatory action relating to thalidomide, to lead in the air, to the risks posed by many other outdoor air pollutants, and to industrial exposure to many chemicals.

Instead, we have wisely adopted criteria for taking appropriate remedial action prior to actual "body counts." Thus, for example, any substance which in any one animal test, regardless of the level of exposure, has been shown to cause cancer in any animal species is banned as a food additive. The EPA statute relating to the regulation of airborne pollutants requires only that the EPA find that the pollutant "may reasonably be anticipated to result in an increase in mortality;" not that it be shown conclusively or beyond a reasonable doubt to have done so.

Under a recent unified cancer policy adopted by the conservative and generally anti-regulatory Reagan Administration, any substance which has been found to cause cancer at any exposure level in any animal species must be regarded as a carcinogenic substance and exposure limited "to the extent feasible." Tobacco smoke, as well as many of its individual components, clearly falls within this standard, even in the absence of any of the evidence discussed in this article. Finally, if indoor air quality were held to the same standards currently applied to the outdoor air pollution, smoking would have to be severely restricted in virtually all public places.

Ironically, CU actually applied outdoor air quality standards to indoor air in its analysis of the health risks of kerosene heaters in the very same *Consumer Reports* issue [P. 75, C. 1], yet strangely did not do the same for the toxic substances from cigarettes.

In short, if CU had applied any of the current and generally accepted scientific, legislative, or regulatory standards to the issue of the health hazards of ambient tobacco smoke, it would have concluded that the risk has been established clearly enough to require immediate remedial action. CU's failure even to mention any of these accepted standards, and its suggestion that the risks associated with ambient tobacco smoke must be judged by some far higher standards, make the article even more misleading. Indeed, for a magazine which has warned its readers of dangers based on far, far weaker evidence—e.g., radioactivity from smoke detectors and radiation from microwave ovens—the conclusions of its article on ambient tobacco smoke go so far as to strongly suggest not only scientific negligence, but clear bias.

13. Still further evidence of this bias is found in the concluding portion of the article, which suggests that the problems ambient tobacco smoke cause are, at most, "discomfort" or "nuisance" to most people [P. 84, C. 2 and 3.] Even assuming, for the sake of argument, that ambient tobacco smoke does not cause lung cancer, teary, sore and watering eyes; coughs; sore throat and hoarseness; sneezing and dripping noses; headaches; and so on, can hardly be characterized with any fairness as mere discomfort or nuisance.

Indeed, a frequent tactic of the tobacco industry is to argue that ambient tobacco smoke causes no more than a "discomfort" or "nuisance," and thus should no more be regulated than other alleged discomforts or nuisances. They argued, for example, that a crying baby was more of a nuisance on an airplane than smoking, and thus smokers should not be separated from other passengers unless infants and their parents were also. Yet, as pointed out previously, even putting aside the question of the issue of lung cancer, ambient tobacco smoke clearly causes serious measurable and observable irritations in most nonsmokers, and far more serious consequences in the tens of millions who have a variety of physical conditions. Attempts to term this mere "discomfort" or "nuisance," and thus minimize the problem, are still further evidence of the bias which permeated the article.

14. Finally, the article closes by stating that "*draconian* measures may foster contention and wind up being observed largely in the breach." Characterizing the laws currently restricting smoking in workplaces and other public facilities as "draconian" is not only editorializing in the context of a supposedly objective article on a scientific issue, but also totally unsupported. San Francisco has virtually the strictest law in the country regulating smoking in the workplace, since it permits any one nonsmoker to totally ban smoking in his or her office. Yet, despite arguments by the tobacco industry that such a law would have drastic adverse consequences, it has now been in effect for some time in the City by the Bay. The *Wall Street Journal,* a publication sympathetic to businesses and strongly antiregulatory in its editorial philosophy, nevertheless has reported that the law is working well; that there are very few enforcement problems; and that it is generally accepted by nonsmokers, smokers, and employers. Similar articles concerning other very strict laws regulating smoking in the workplace likewise reach the same conclusion. Indeed, if CU had investigated further, it would have found that many surveys—including some by the tobacco industry itself—show that the majority of smokers as well as nonsmokers favor increased restrictions on smoking in public places. In summary, the use of the word "draconian" was totally uncalled-for editorializing; has little support of which we are aware; and in context was not only misleading, but also further evidence of deliberate bias.

Readers who share ASH's views on this issue may wish to write to the president of the Consumers Union board, James A. Guest, Secretary, Agency of Development and Community Affairs, 109 State Street, Montpelier, VT 05602, and to Dr. Joel Nobel, Emergency Care Research Institute, 5200 Butler Pike, Plymouth Meeting, PA 19462, to tell them how you feel. You may receive in response some explanation from CU itself. If you do, please let ASH know and enclose a copy of any such material so that we will have an opportunity to respond. In any event, we hope that the detailed analysis above will prove useful to those who may have been confused or disconcerted by CU's article.

WHY DID CU APPLY DIFFERENT STANDARDS IN ASSESSING THE RISKS POSED BY CIGARETTE SMOKE AND KEROSENE HEATER FUMES?

"We are not here talking about regulations intended to apply performance or design standards to a hazardous product, such as kerosene heaters, which we support.

Nor are we talking about restrictions on the promotion or sale of a dangerous product, such as cigarettes, which we also support.

Rather we are talking about the extent to which available scientific evidence about the effects of passive smoking supports legal restrictions on the behavior of nicotine addicts."

Letter to ASH from Rhoda H. Karpatkin, CU Executive Director, 256 Washington St., Mt. Vernon, NY 10553 (914) 562-0102

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Maternal Smoking Causes Ethical Problems

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health law, suggests that eventually parents could face "civil or criminal charges if they negligently or purposefully bring defective fetuses to term when, by reasonable behavior, they could have avoided such a tragedy."

Many feminists argue that women who are not mentally incompetent have a right to conduct their pregnancies as they wish free from interference. But governments have already overridden this proposed "right" in several instances. For example, courts have required pregnant women to accept blood transfusions over their objections where it was necessary to protect the health of the fetus. And in an even closer analogy, a Baltimore court ordered a mother on narcotics to enter a drug rehabilitation program and to submit to weekly urine tests to ensure that she was drug-free. California, Georgia, and Mississippi have statutes, designed to protect fetuses, that have sometimes been used against mothers. In one case a mother was sued by the father of her child because she took a drug during pregnancy that caused discoloration of her baby's teeth.

The U.S. Supreme Court has consistently held that a woman's decision not to continue a pregnancy is protected under the constitutional right of privacy, and that she may abort the fetus without governmental interference, at least early in her pregnancy. But the Court has never ruled that having decided to carry the fetus to term, a woman has a right to intentionally or even negligently inflict harm on a fetus that will eventually become a human baby. Indeed, some fetal-rights activists support the woman's right to choose an abortion, but insist that once she decides against it, she loses some of her constitutionally protected bodily freedom, and is obligated to do all that she reasonably can to ensure the birth of a healthy baby.

For years the law has been clear that a person who through negligence causes injury to a fetus is legally liable to the child once it is born. For example, an automobile driver who negligently hits a pregnant woman is liable not only for her injuries (if any), but also for injuries to her child when it is born. Likewise, a drug company that negligently fails to warn a mother-to-be about the dangers of a drug may be liable if it eventually causes injury to the child. However, although a woman is obviously closer to her unborn child and therefore arguably has an even greater duty to guard it from harm, imposing a legal duty to take reasonable care may significantly intrude upon her personal habits or choices.

Spokespersons for "right-to-life" groups, which strongly oppose abortions because they believe the fetus is a "person" entitled to full legal protection, have been strangely silent about threats to the fetus other than abortion—such as the pregnant woman's use of hard drugs, alcohol abuse, or smoking—that likewise endanger and frequently cause the death of the fetus. Senator Jesse Helms has been particularly singled out because of his outspoken views on the rights of the fetus and his unswerving support for cigarette smoking. But most women's groups and

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THE NEW YORK TIMES, SATURDAY, MARCH 9, 1985

Abusing Children by Smoking

By William G. Cahan

Most of us know about the dangers of smoking. And most of us are deeply concerned about child abuse. But what we have overlooked is the child abuse caused by smokers. In fact, smoking adults inflict serious damage upon the developing child, starting with its embryonal life and continuing throughout its formative years. A nursing baby may receive nicotine in breast milk or by inhaling it.

Physicians have long cautioned pregnant women to be sparing in their use of alcohol, certain drugs, caffeine and diagnostic X-rays for fear of injuring the fetus. Only recently have they extended these warnings to cigarette smoking. Although there is still some skepticism about this, increasing numbers of scientific studies show that regular smoking can injure the fetus in several ways, some of which are immediately apparent while others develop more slowly and insidiously.

William G. Cahan, M.D., is attending surgeon at Memorial Sloan-Kettering Cancer Center and emeritus professor of surgery at the Cornell University Medical College.

For example, within minutes each cigarette puff introduces carbon monoxide and nicotine into the maternal blood. The former reduces the ability of the blood to carry oxygen, while the latter constricts the placental blood vessels, diminishing their life-supporting flow. As a result, the unborn child is temporarily deprived of its normal amount of oxygen. If this deprivation is repeated often enough, it could irreparably damage the fetal brain, an organ uniquely sensitive to a lack of oxygen.

Besides its effect on blood vessels, nicotine crosses the placenta to the fetus where it acts as a cardiovascular stimulant and a respiratory depressant. This reaction was demonstrated when a group of pregnant women, smoking only two cigarettes, experienced a rapid rise in blood pressure and pulse rate. Within five minutes, the heart rate of their fetuses accelerated and was accompanied by abnormal breathing-like motions—both a sign of fetal distress.

These findings carry serious implications if one multiplies the five puffs per cigarette inhaled by the average smoker by 20 (the number of cigarettes in a pack-a-day habit) and then by 270 (the number of days for gestation). This means that the fetus is subjected to at least 27,000 physical-chemical insults, beginning with its earliest stages of rapid cellular division, when it is most vulnerable, and continuing through its uterine life. This also applies to the many other harmful components of tobacco smoke (for example, cyanide), some of which could prove even more noxious than nicotine.

What is the cumulative impact of these repeated assaults on the fetus? Experiments on animals show that the byproducts of tobacco smoke can upset fetal metabolism and the endocrine gland system. More ominously, the byproducts are known to derange the unborn's genetic material, the cell's DNA.

This disruption of fundamental mechanisms, so vital for normal fetal development, could explain why one in five unsuccessful pregnancies occurs in women who smoke regularly. Or, more specifically, why these women have a higher incidence of spontaneous abortions, stillbirths and premature deliveries than nonsmokers. Their babies are apt to be smaller at birth, more susceptible to diseases of early infancy and are at increased risk of dying at that time. The babies have a tendency to be born with cleft palates and hare lips and, later on, may exhibit such difficulties as shortness in size, lower scores in social adjustment, behavioral problems, impaired reading abilities, hyperactivity and mental retardation.

Chronic inhalation of cigarette smoke is now known to be more than just a temporary nuisance: it may contribute to cancer in later life. Moreover, a growing child, continually exposed to it, is prone to develop ear, nose and throat infections, bronchitis, pneumonia, asthmatic attacks and decreased lung efficiency. There are, of course, other consequences: for example, adult smokers create an environment in which young people are tempted to begin smoking.

Realizing all this, what responsible woman can persist in a habit so threatening to her young? Using self-discipline, she can minimize the risk of a complicated pregnancy and imposing lifelong physical and mental handicaps upon her child.

Clergymen, educators, parent-teachers' associations and legislators should speak out against tobacco just as they do against alcohol, drugs, drunken driving, radioactive-waste disposal, dioxin and abortion. Because more than 50 million Americans smoke, this form of child abuse may be the most pervasive of all. □

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Public Smoking Is Not a Right

By John F. Banzhaf III

Considerable confusion is created when people seek—including law professors who should know better—to equate the legal and ethical right nonsmokers have to protect their health with a so-called "right to, smoke," and to argue that one must be balanced against the other. Logic, law, and public attitudes clearly indicate that smoking, at least in public places, is a practice or habit rather than a right; a habit which, like many others, can and is limited when it adversely affects others.

Although people who chew tobacco derive much the same satisfaction from the nicotine as those who smoke it, and may have the same addiction or habituation to the practice, no one today would seriously argue that there is a legal or moral right to be able to chew and spit in public; that offices, public buildings, and the like should provide spittoons; or that a chewing-and-spitting section must be established on airplanes. This is true even though the health hazards for bystanders are probably lower with spitting than with smoking, since people sharing the room with spitters are not required to ingest the toxic substances that the latter produce.

People who burn incense—and who, like smokers, derive some satisfaction from an activity that puts smoke into the air—would never assume a right to "light up" in a restaurant or public building, nor insist that employers permit it in the workspace shared by others. Other practices that are analogous to smoking, in that they bring some pleasure to the doer while adversely affecting his neighbors, include playing a musical instrument, listening to loud music, wearing improper attire, using loud or profane speech, and masturbating—all of which are clearly habits rather than rights, and all of which are frequently restricted in the same public places where smokers assert a "right." Indeed, even practices that may be necessary rather than gratifying, and that only offend rather than harm bystanders—and thus have a better claim to being "rights"—are generally curtailed in public by common understanding; e.g., injecting insulin, and changing a baby's messy diaper. Obviously all of these practices are not "rights" when done in public places, any more than smoking is when viewed from the proper perspective.

Courts, legislatures, and administrative bodies have long recognized this basic distinction. The right to be free from harm caused deliberately by another is one of the most fundamental rights, and is therefore protected in all legal systems. Hundreds of legislative bodies have passed laws or ordinances codifying the right to be protected from the harmful effects of tobacco smoke in various public places, but none has recognized, or even attempted to establish, a corresponding right to smoke. Even in situations not covered by statutes, courts under a variety of theories have extended legal protection to nonsmokers, while denying it to smokers.

Another way to analyze the issue is to remember that smoking is a form of air pollution. To protect us from the risks of air pollution—often on less evidence than exists about tobacco smoke—governments regulate our exposure to a wide variety of airborne substances in the workplace, public buildings, and even the home. Some restrictions even curtail what some might argue are personal rights: to burn leaves in one's own back yard, to drive a "muscle car," to use a fireplace, and in some apartment buildings even to use a barbecue. Why then should smoking—the most prevalent and dangerous form of indoor air pollution—be any exception?

Some try to argue that governmental restrictions of smoking in public places will lead to "Big Brother" cracking down on the consumption of alcoholic beverages, or fattening foods, or even mandating exercise, all for reasons of health and to hold down medical costs. But there is a fundamental difference because the drinker, the eater, and the slothful do not directly endanger the health of those around them, whereas the smoker does. It is the risk he causes those immediately around him, not the risk he creates for himself, that

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Smokers Have Rights, Too

By Ernest van den Haag

Enough is enough, and we have seen enough of the harassment and intimidation of smokers.

True, smoking is bad for the smoker's health, and when he finally suffers his heart attack, or gets lung cancer, abstinent taxpayers have to pay for his hospitalization. As a result, many nonsmokers favor laws prohibiting smoking, at least in public and semipublic places. This may seem logical, but it puts us, as a society, on a dangerous, slippery slope, raising the prospect that we will soon be preventing all kinds of other people from doing what they want because of hazards to their health and our pocketbooks.

After all, taxpayers are also compelled to help pay for the hospitalization of drinkers, obese overeaters and those too lazy to exercise. Should we, then, have legal regulation of eating, drinking and exercising? How much liberty — the liberty to enjoy one's own habits and even vices — are we willing to sacrifice?

People smoke, or drink, or eat the wrong things, despite bad physical effects, because of the psycholbgical gratification they obtain. In his 80's, Sigmund Freud underwent the first of more than 30 painful operations for oral cancer. He was told that it was caused by cigar smoking, but he continued nevertheless. In his 72d year he wrote: "I owe to the cigar a great intensification of my capacity to work and . . . of my self-control." By then, he had an artificial jaw and palate. He smoked till he died, in his 80's.

Most nonsmokers simply cannot understand this, and they scornfully label it "addiction." I prefer to call it a dependence, like reliance on a lover. Such a reliance may be enjoyable and productive; and it may have bad, even tragic, effects as well. But even when the bad effects become clear, one may want to continue because of the gratifications: the habit, once formed, is usually hard to shake. If one is deprived of the lover, or of the cigars, one suffers withdrawal symptoms, be they physical or psychological. Love is seldom called an addiction. Why should smoking be?

The nonsmoking taxpayer is right about one thing: he should not have to pay for hospitalizations caused by smoking. Instead, we should impose a Federal tax on tobacco sufficient to pay all the extra costs that smoking causes. Insurance companies, too, might charge higher rates to smokers and drinkers.

But what about the health effects of "passive smoking" and the annoyance that smoking may cause?

Some people are indeed allergic to smoke, and any civilized person will avoid smoking when they are around. Allergic people should, in turn, avoid places and occasions known to be smoky — discothèques, bars or dinner with Winston Churchill. But allergies to smoking have increased amazingly in recent years — a sudden increase that suggests that many of them are hysterical, or faked, to justify the imposition or the nonsmoker's preference on smokers.

In fact, dubious statistics to the contrary and except in instances of rare genuine allergies, smoking does not ordinarily endanger the health of nonsmokers unless they are exposed to smoke for a long time in an unventilated space.

As for annoyance, life is full of annoyances, some hazardous to health, that we must tolerate for the sake of other people, who want, or need, to do what annoys us. We all have to breathe polluted air, even if we never ride in a car or bus, simply because others want to.

Far more people refrain from smoking now than in the past — which is fine. But harassment will not increase their number. Nor will the prohibition of cigarette advertising. Marijuana does quite well without such promotion. People learn to smoke, or drink, from others, not from advertisements.

Is there nothing to be done? Certainly, wherever possible we should separate nonsmokers from smokers and provide ventilation. We do so now on big airplanes. But in most other places, in offices and restaurants, for instance, smokers and nonsmokers will have to reply on mutual tolerance. Courtesy cannot be replaced by one-sided and unenforceable regulations which, even if temporarily effective, will in the long run simply discredit the law. □

Ernest van den Haag is professor of jurisprudence and public policy at Fordham University Law School.

THE NEW YORK TIMES, TUESDAY, APRIL 9, 1985

Maternal Smoking

Continued from page 11

publications, many of which support the freedom of women to choose an abortion, have also been reluctant to take a stand on the harm smoking causes to children both before and after they are born, on the exploitation of the women's movement by the tobacco industry, and related issues.

In any event, the health hazards posed to the fetus by maternal smoking cannot long continue to be ignored, not as the evidence mounts and more campaigns are launched to reduce infant mortality. ASH does not take any position on the issue of abortion, but it does suggest that the issue of maternal smoking must be addressed by people of all different viewpoints.

Public Smoking Is Not a Right

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justifies the limits on his so-called "right" to smoke in public.

In any event, we do prohibit driving while drunk, public intoxication, and even the consumption of alcoholic beverages in many public places; we do limit the use of products, such as cyclamate-sweetened drinks, nicotine chewing gum, and the smoking of marijuana (even in private), that harm no one but the user; and states are increasingly requiring the use of seat belts and/or motorcycle helmets based largely on arguments of cost savings. Again, how can one logically argue that smoking, which causes more deaths than all of these other products combined, should be immune from any governmental regulation as some kind of "right"?

It is now too well established to doubt that smoking causes serious health problems for an estimated 30 to 40 million nonsmoking Americans with asthma, hay fever, sinusitis, various allergies, and a wide variety of other conditions; any large hospital or medical center can describe their suffering. It is also well known that tobacco smoke can cause readily observable physical irritations (e.g., red, sore eyes) in the majority of completely healthy nonsmokers, as a random sample of nonsmokers will indicate. And the U.S. Surgeon General has said that there is "very solid" evidence that cigarette smoking can cause lung disease in nonsmokers. The evidence includes more than a dozen reports in leading medical journals showing that it can cause thousands of cases of lung cancer in *non*smokers every year.

The final myth is that common courtesy is the answer to the health hazards of ambient tobacco smoke. If common courtesy is the answer, why are so many people driven from their jobs by tobacco smoke; why is drifting tobacco smoke one of the top three complaints in restaurants; why does survey after survey show an overwhelming majority of *smokers*, as well as nonsmokers, favoring restriction on smoking in public places; and why are nonsmokers subjected in so many places to clouds of tobacco smoke that they are forced to inhale. The answer is that individual courtesy is not a satisfactory protection in a society in which we are forced to be in close proximity with so many different people so often. Legislation, which separates smokers from nonsmokers wherever possible, and which prohibits smoking where necessary, is the only real answer to America's number one preventable health problem.

Two Networks Refuse to Air "Puffing Fetus" Spots

A strong antismoking public service announcement, designed to dramatize the health risks caused by maternal smoking, has been rejected by the CBS and NBC television networks as too graphic. It shows a simulated fetus puffing on a cigarette.

The message was produced for the American Cancer Society by Joseph Vogt, a creative filmmaker. In it, what appears to be a fetus (actually a plastic puppet) inside a bubble-like sac clutches a cigarette in its tiny right hand as a narrator asks, "Would you give a cigarette to your unborn child?" Then, just as the narrator says, "You do, every time you smoke when you're pregnant," the fetus draws the cigarette to its mouth, inhales and lets out a puff of smoke.

CBS refused to air the antismoking message because it was "far too graphic for presentation on CBS." NBC likewise rejected the spot, saying that it "might be offensive to some people." "We have a policy that [public service announcements] have to advocate the positive side of an issue; this did not." Apparently the spokesman did not explain what the positive side of the issue was.

ABC's vice president for broadcast standards, Alan Wurtzel, reacted differently, saying "I know the message is important, powerful, unusual and very startling. What you're seeing is a visual metaphor. Everyone knows fetuses don't smoke, so frankly I don't understand all the attention this is getting. No one has demonstrated in what way it's offensive," he added. "I think cancer is offensive."

Here is what you can do to help:

1. Write to Mr. Wurtzel at ABC, 1330 Avenue of the Americas, New York, NY 10019-5402 (212) 887-7777, in support of his decision, and to Thomas Wyman, CBS, Inc., 51 W. 52nd Street, New York, NY 10019-6101, (212) 975-4321, and Albert Jerome, NBC, 30 Rockefeller Plaza, New York, NY 10112-0001, (212) 664-4444, telling them what you think of their attitude. You may wish to remind them of other things that appear on their networks and that you feel are offensive or too graphic.

2. Write to TV stations in your area and ask them to present the spot, reminding them that there is an important "community need" for this type of information.

* * * * *

In recommending an end to all promotion and advertising of cigarettes, the National Advisory Council on Drug Abuse conceded that the print media would probably feel the effects of a ban most acutely. But, said panel member Lloyd Johnston, "the electronic media survived the restrictions on cigarette advertising, and we believe the print media will as well."

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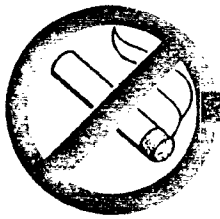

FIRST WORLD CONFERENCE ON NONSMOKERS' RIGHTS

Tentative Agenda

Friday Evening

8:00 - 10:00 OPENING PLENARY SESSION—This opening session is designed to permit those who can arrive the evening before to meet together informally to discuss mutual concerns and to exchange ideas.

Saturday

8:30 - 9:00 REGISTRATION
Sign up, get badge, pick up materials, find seat, etc.

9:00 - 9:50 I. PROBLEMS OF AMBIENT SMOKE, AND APPROACHES TO THE PROBLEM
1. The three kinds of health hazards posed by ambient tobacco smoke
2. Brief review of evidence, and of standards of proof for corrective action
3. Various solutions: separation, barriers, ventilation, bans, etc.
4. Strategy and tactics for individual nonsmokers
5. Overview of things organized groups can do

9:50 - 10:00 TEN-MINUTE BREAK

10:00 - 10:50 II. STARTING A NONSMOKERS'-RIGHTS GROUP*
1. Why start a group, and is it worth it?
2. How to locate and attract initial members
3. Coordinating with other existing organizations
4. Type of organization: e.g., informal, trust, corporation, etc.
5. Tax considerations, and potential pitfalls

*Leaders of established nonsmokers'-rights groups will meet with the press, 10-11 a.m.

10:50 - 11:00 TEN-MINUTE BREAK

11:00 - 11:50 III. OPERATING A NONSMOKERS'-RIGHTS GROUP
1. Activities to benefit, attract, and hold members
2. Activities to advance goals and fight smoking
3. Raising funds from members, foundations, and elsewhere
4. Publications; producing them and reading others
5. Data processing for antismoking organizations

11:50 - 12:00 TEN-MINUTE BREAK

12:00 - 1:00 IV. LEGISLATIVE APPROACHES TO CONTROLLING SMOKING
1. Types of bills, and variety of approaches
2. How to draft effective legislation
3. Lobbying for (or against) legislation
4. Compromise and negotiation
5. Special tips and strategies

1:00 - 2:00 LUNCH BREAK

2:00 - 2:50 V. DEALING WITH SMOKING IN THE WORKPLACE
1. Step-by-step approaches for employees to deal with problem
2. Arguments to support smoking limitations
3. Examples of businesses that have limited smoking, to use as models
4. Status of the law, and various legal theories for relief
5. Realities and problems of taking legal action

2:50 - 3:00 TEN-MINUTE BREAK

3:00 - 3:50 VI. OTHER PROBLEM AREAS, AND OTHER APPROACHES
1. Dealing with smoking in restaurants
2. Dealing with smoking in hospitals and health-care facilities
3. Dealing with smoking on transportation facilities
4. Economic approaches and attacks on the smoking problem generally
5. Torts litigation as a means of attacking smoking generally

3:50 - 4:00 TEN-MINUTE BREAK

4:00 - 5:00 VII. PUBLICITY, DEBATING, AND FILING EFFECTIVE COMPLAINTS
1. Getting publicity generally, why and how
2. Drafting a press release, and holding a press conference
3. Debating: arguments, strategy, tactics, and tips generally
4. General techniques for filing effective complaints
5. Filing Fairness Doctrine, Personal Attack, Advertising, and Freedom of Information Act complaints

5:00 - 5:30 QUESTION PERIOD

5:30 - 7:30 BREAK FOR DUTCH-TREAT DINNER

7:30 - 10:00 CLOSING PLENARY SESSION—This closing session is designed to permit unstructured discussion of any remaining questions, or any ideas or suggestions attendees wish to make. ASH's Board of Trustees will also attend, so that attendees may also address questions or suggestions to them.

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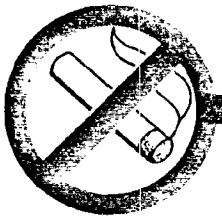
ANNOUNCEMENT AND REGISTRATION FORM
(May be duplicated for mailing to friends, associates, and organizations)



FIRST WORLD CONFERENCE ON NONSMOKERS' RIGHTS

First World Conference on Nonsmokers' Rights
Saturday, October 5, 1985, Washington, D.C.

A program designed not to present papers and pass resolutions,
but to teach people how to be more effective
in the fight for nonsmokers' rights

Open to all present or potential nonsmokers'-rights activists!

Topics To Be Covered

- Effects of ambient tobacco smoke
- How to limit exposure
- Starting a nonsmokers'-rights group
- Tax considerations for activist groups
- Drafting effective legislation
- Lobbying, negotiation, and compromise
- Dealing with workplace smoking complaints
- Persuading businesses to act voluntarily
- Debating smoking-related issues
- Drafting effective complaints
- Everyday tactics for nonsmokers
- And much more!

Special Events

- Opening Plenary Session
- Question and Answer Session
- Dutch-Treat Dinner
- Leaders' Press Conference
- Closing Plenary Session

Total cost, including all materials but NOT including food, lodging*, transportation, etc., is ONLY $75!

*Information concerning food and lodging will be sent upon receipt of registration. Attendees must make their own transportation arrangements.

IMPORTANT NOTICE: Because all conference sessions will be held in one room, ATTENDANCE WILL BE STRICTLY LIMITED. It is expected that space will be available only by advance registration. Therefore, reservations SHOULD BE MADE AS SOON AS POSSIBLE, using the registration form below. Spaces will be reserved in the order that fully paid applications are received by ASH.

REGISTRATION FORM—FIRST WORLD CONFERENCE ON NONSMOKERS' RIGHTS—OCTOBER 5, 1985
ALL INFORMATION MUST BE PRINTED IN BLOCK CAPITAL LETTERS

LAST NAME FIRST NAME

ADDRESS

CITY STATE ZIP

HOME PHONE ( ) WORK PHONE ( )

If affiliated with any local or state antismoking organization, please list:

FULL NAME OF GROUP

MAILING ADDRESS

CITY STATE ZIP

CHIEF CONTACT PERSON PHONE ( )

Please enclose a check for $75 made payable to "ASH—CONFERENCE." Registration forms not accompanied by a check will not be accepted. Money will be refunded only if there are insufficient subscriptions, or in the event of a serious illness attested to by a doctor's letter.

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EXECUTIVE DIRECTOR'S REPORT

John F. Banzhaf III
Executive Director

PROF. VAN DEN HAAG wrote an ASH supporter: "You ask why 'smokers have a legal right to smoke.' They do whenever and wherever there is no legal prohibition or rule imposed by the proprietor of the property on which smoking would occur. Contrary to Mr. Banzhaf's interpretation on the occasion to which he refers smoking was permitted."

The Fordham law prof's answer seems to be as logical as it is literate, since most establishments have no rule prohibiting pinching, or coughing in the face of another, although both are clearly civil wrongs (torts). By the way, readers supported my action in dousing Prof. van den Haag's cigar on a recent TV program by a margin of over 23 to 1. Many said they would have done even more!

FUND RAISING PERSON NEEDED: ASH's Development Director, who has been with ASH virtually from the start, is about to retire. Without Mrs. Winnings ASH would never have survived, and it will be very difficult to replace her. Nevertheless, we must, so ASH is searching for individuals or organizations with the experience and interest to help us raise the money needed to carry out our work. ASH is also looking for someone in the D.C. area with bookkeeping experience to help on a part-time basis. Resumés and letters only, please, NO PHONE CALLS!

FEDERAL CIGARETTE TAXES, due to drop to 8¢ a pack from 16¢ this fall, may remain at 16¢, particularly if Members of Congress get enough calls and letters. ASH and other groups are supporting the 16¢ rate, noting that higher taxes decrease consumption and force smokers to pay more of the costs of their habit.

The total cost of smoking is over $3.00 a pack, most of which is now paid by nonsmokers in higher taxes, etc.; a form of hidden subsidy to the tobacco industry. At least 22 states are also considering raising cigarette taxes, and state legislators' votes may also be affected by letters and calls.

Congressman Thomas E. Petri suggests that ASH supporters also write about the Tobacco Deregulation Act of 1985 which would finally end government support for the tobacco industry and save tens of millions of dollars each year.

ONLY 28% of adults smoke, according to a recent Harris poll; the lowest % ever recorded, and down from 30%.

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